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ABSTRACT

To assist community colleges in the South in develcping curriculums, planning programs, and recruiting and evaluating students for mental health training, and to work with mental health agencies in job placement for graduates, a 5-year project was conducted under a grant from the Natonal Institute of Mental Health. Using a developmental approach in preference to a job factoring approach to produce mental health "generalists" instead of specialists, a program will be implemented by developing and achieving curricular objectives. A discussion of these goals includes a definition of basic competencies, i.e. levels of proficiency necessary in knowledge, skills, attitudes, and values; suggestions for obtaining this "core of competence"; and problems encountered which still must be resolved. Innovative techniques used in community college mental health training programs in the South are described, stressing student self-awareness and involvement in "real-life" activities. Job placement, in addition to worker preparation, is not to be neglected. (AG)

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PLANS FOR TEACHING MENTAL HEALTH WORKERS

Community College Curriculum Objectives

February, 1971

By

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and

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FOREWORD

Under a grant from the National Institute of Mental Health, the Southern Regional Education Board is conducting a five-year project to assist the community colleges of the South that have elected to develop mental health worker training programs to better know how to go about planning programs, developing curricula, and recruiting and evaluating students. The project also works with the mental health agencies in which these graduates might work to help the agencies develop job descriptions, career ladders and realistic patterns of introducing and using the workers.

This publication grew from a series of the project's activities that were concerned with curriculum development for community college mental health worker programs.

The ideal mental health worker curriculum would represent a fine balance among academic goals of the college, theoretical goals of leaders in the field, practical goals of future employers, and idealistic goals of students. However, developing a curriculum of this sort is a difficult task. There are no "right" or "wrong" answers to many of the problems faced by curriculum planners of new mental health worker programs. But however complex and interrelated the problems are, answers must be sought and students educated.

In our conventional method of curriculum development, we have been like the crayfish--we have continually moved forward while looking backward. Marshall McLuhan refers to this approach as "looking at the world through a rearview mirror." But there is no other way for humans to advance. Our

forecasts of the future are based on our knowledge of the past, and our problems today were considered to be our accomplishments yesterday.

Obviously we cannot have instant education; therefore, curricula will always be attempting to meet the mental health needs recognized two to five years earlier. Since the basic concept of education and curriculum development is that one group of people (the faculty) knows what another group (the learners) needs to know, the mental health worker movement, like other educational endeavors, will have to continue to operate at the level of current mental health knowledge. Accomplishments at the practical level may seem at times to fall short of the utopian level of the future, but nonetheless they are accomplishments. This guideline is only a practical accomplishment, not an ultimate answer.

James B. King
Project Director
Community College Mental
Health Worker

SECTION I

BACKGROUND

The 1960's will be recorded in the history of mental health services as the decade when Americans attacked many of the problems that had long plagued mental health delivery systems in the nation. It was during the Sixties that mental health services made a major move from the large mental hospitals to the community. It was also during the Sixties that individuals with less than graduate professional training were recognized for the roles that they can play in working with individuals who have emotional problems or mental disabilities.

At the beginning of the Sixties, Dr. George Albee[1] made a strong plea for the development of new kinds of workers who could be trained in a shorter period of time than the traditional six to eight years needed to train professionals in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing. In his book, *Mental Health Manpower Trends*, Albee documented the critical need for more service personnel in mental health. In conjunction with Dr. Albee's plea and the development of community mental health centers through the nation came another significant development in the United States--the growth of two-year colleges. While the community mental health center movement increased the need for more locally based, therapeutically trained manpower, the community college movement provided a potential local source for training new levels of mental health workers to meet these manpower needs.

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[1]George W. Albee, *Mental Health Manpower Trends*, Joint Commission on Mental Illness and Health, Monograph #3. (New York: Basic Books, 1959).

The Southern Regional Education Board (SREB), with financial assistance from the National Institute of Mental Health (NIMH), reacted to these developments by sponsoring a conference to study the role of the community college in educating and training mental health workers. As a result of this conference, held in 1966, SREB applied to NIMH for a five-year grant to promote the development of community college mental health worker programs in the 14-state Southern region. The application stated that SREB would work with four or five states to:

> determine the kinds of job functions that community college mental health graduates might perform
>
> facilitate the establishment of job descriptions and funded positions in community service agencies
>
> facilitate the development of community college training programs and curricula in mental health
>
> disseminate information regarding developments in community college mental health programs
>
> report and analyze experiences of various states in the community college mental health worker movement.

In 1965, NIMH funded an experimental two-year mental health worker education program at the Fort Wayne Campus of Purdue University. During the next two years, NIMH funded mental health programs at Daytona Beach Junior College in Florida; Metropolitan State College in Denver, Colorado; Sinclair Community College in Dayton, Ohio; Jefferson State Junior College in Birmingham, Alabama; Community College of Philadelphia, Pennsylvania; and Greenville Community College in Massachusetts. Since then many other community college mental health worker programs have been developed throughout the nation without waiting for evaluation of the experimental pilot programs.

In the spring of 1969, SREB sponsored a symposium to study roles and functions for different levels of mental health workers. From that symposium, the report entitled *Roles and Functions for Mental Health Workers*, was published in December of 1969.[2]

During 1970, SREB sponsored a number of curriculum development meetings designed to analyze and improve the curricula of community college mental health worker programs in the South. The objectives of the meetings were:

> to clarify the purposes of community college mental health worker programs in the South
>
> to identify and define the objectives and goals of community college mental health programs in the region
>
> to compare various methods used to accomplish the objectives and goals of mental health programs, especially with regard to field experience
>
> to discuss philosophical and theoretical concepts underlying mental health or mental retardation curricula in community colleges in the region
>
> to provide community college people an opportunity to exchange ideas concerning curricula in mental health programs.

The first of the curriculum development meetings was held in Atlanta on January 20-23, 1970. Participants were representatives of the 17 active community college mental health worker programs in the region: Dr. John True, Program Director from the Purdue, Fort Wayne, Indiana, Mental Health Program; representatives from NIMH, SREB, and the Council on Social Work Education (CSWE); and two field work supervisors from the Fort Logan Mental

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[2]Southern Regional Education Board, *Roles and Functions for Mental Health Workers*. (Atlanta: 1969).

Health Center, Denver, and Spring Grove State Hospital in Baltimore.

The second curriculum development meeting was also held in Atlanta, May 1-2, 1970. The same 17 community college mental health worker program directors attended as well as a number of program directors from outside the SREB region and representatives of colleges planning to initiate associate degree programs. In addition to the program directors, 30 graduates from 11 of the 12 community colleges in the nation that had graduated students in 1969 attended. They were asked to discuss their roles and functions in their current jobs (all in mental health) and to critique their own education and its relevance to their present jobs.

These two meetings provided the first regional (and somewhat national) exposure of the college program directors to each other and to community college mental health graduates. Only six of the 17 SREB colleges had graduated students at that time.

In the fall of 1970, a series of committee meetings was held to further refine the program objectives and goals that had been identified during the regional meetings in the spring. These committees were made up of the SREB project staff and three to five program directors from colleges in the South. The committees considered objectives related to knowledge, skills and attitudes that community college graduates would be expected to have. Committee meetings were held in Baltimore, Maryland, October 8-9, 1970; Southern Pines, North Carolina, October 29-30, 1970; Greenville, South Carolina, November 17-18, 1970; Morganton, North Carolina, November 19-20, 1970; and New Orleans, Louisiana, February 17-19, 1971.

This publication is a result of all of these meetings plus information gathered by the SREB project staff from mental health programs throughout the nation.

The Problem

John Dewey said that the most difficult part of solving a problem is properly identifying the problem. Society has often allocated billions of dollars and millions of man hours to treatment of a sympton instead of the problem itself. The basic problem, of course, continued to exist.

Dr. Albee pointed out that there was no conceivable way to meet manpower needs in mental health in the United States if we insisted on only training the traditional kinds of mental health professionals with the traditional 6 or 8 years of professional training. He made a strong plea for the development of new levels of mental health workers who could be trained in a shorter period of time. Dr. Albee viewed the mental health manpower situation and defined the problem as a quantitative one--we need more mental health workers.

The community colleges have responded to this quantitative problem, but during the formative years of the community college mental health worker movement a new aspect of the mental health manpower situation was identified and the problem redefined. The need is not to merely produce more workers of traditional kinds, but to produce new kinds of workers.

Approaches to Developing New Workers

During the manpower symposia held in 1969 it was pointed out by several employment research experts--and reinforced by the symposia participants--that

there are two basic approaches to the creation of jobs for new levels of workers: the job factoring approach and the developmental approach.

Job Factoring

In the job factoring approach, existing professional jobs are broken down into separate tasks and activities and the pieces assigned to various levels of workers. The pieces assigned to a new level worker are likely to be the more boresome, choresome, and least challenging aspects of the work. This worker will function as an aide or assistant to an existing profession and will be preceived as a "nonprofessional" or "subprofessional" by the "professional." Such jobs are quickly developed and are acceptable to the established professionals, but they are deadend and frustrating to the job holder because they allow him no opportunity to use his own initiative, creativity, or judgement. With this approach, new dimensions to traditional practices are seldom conceived.

The needs of clients are almost always broader than the coverage by the existing professions, and professionals in agency practice tend to function in traditional and fixed ways that may leave the clients' needs unmet in certain important areas. For example, most professionals see clients in an office setting with daytime working schedules, by appointment only and in a one-to-one relationship. In agencies or institutions there may also be additional administrative restrictions such as fee schedules, age restrictions or residence requirements that make it difficult or impossible for clients to have all of their needs met. One inherent fault in the job factoring approach is that it is likely to repeat these same restrictive models without reevaluating gaps in meeting the needs of clients.

The Developmental Approach

On the other hand, the developmental approach is a substantially different procedure which was strongly recommended by several employment research experts, including Dr. Sidney Fine of the W. E. Upjohn Institute for Employment Research.

In the developmental approach the starting point for job development is the needs and problems of clients, their families and communities. After these needs have been identified and described, the procedure moves to determining what tasks and activities should be carried out to meet the needs, regardless of who now carries them out and regardless of whether they are being carried out at all. Then various criteria are applied to decide on logical groupings of activities for assignment to single jobs and to various levels of workers.

The developmental approach is more difficult and more controversial than job factoring, but it may produce jobs that are more responsive to client needs, that are more challenging to job holders, and that allow the professionals to extend their knowledge and competence as widely as possible without becoming hung up on tratitional role models.

These two approaches have many different implications for educational programs and utilization patterns. In education they affect the total educational structure from course content and teaching methodology to the nature of field experience students receive. In utilization patterns these implications can mean complete reappraisal of roles and functions for all levels of workers. Not only does the job factoring approach not change the system but it is based on the presupposition that the system will not change.

The kind of worker that graduates from the community college programs will ultimately depend on the way the problem is defined. If the problem is defined strictly as a quantitative one, then the job factoring approach for identifying the middle level jobs will probably be taken. In this case the curriculum for developing new levels of mental health manpower will be based on a study of tasks necessary to meet the existing needs in mental health institutions and agencies. The procedure is to factor current jobs, classify the tasks into various levels of complexity, and teach community college students the "middle level" tasks according to complexity. Roles and functions of other workers in the system will change very little and the new worker will have to conform to the existing system. With this approach the system itself should not change.

But if the mental health manpower situation is viewed as a qualitative problem as well as a quantitative one, then the developmental approach should be taken when creating new levels of jobs. In this case, a different approach, based on the new theoretical concept, will have to be taken to developing community college curricula.

Participants in the manpower symposium used the developmental approach in attempting to define roles and functions for various levels of mental health workers. They strongly recommended that a "generalist" approach be taken in creating new levels of mental health workers, and the community colleges in the South have responded to that recommendation--every community college surveyed in 1970 stated that it was educating generalists.

The Generalist Concept

There are several major professions in the mental health field. Among these are psychiatry, psychology, social work, nursing, and vocational counseling. Each of these has a few areas of unique, specialized competencies, but they share a great deal of knowledge, skills and attitudes with each other. There appears to be little advantage in trying to decide jurisdictional boundaries between the professions when there are far more overlapping functions than unique and specific functions. In addition, the field of mental health is in considerable transformation and new professional modalities are continually evolving. For example, in community mental health centers professionals are functioning as consultants, educators, outreach workers and aftercare coordinators. None of these roles existed in traditional professional patterns in the past.

The participants in the manpower symposia concluded:

> When one starts from the viewpoint of the client or family, what is needed is not more professional or subprofessional specialists, but more generalists. The fragmentation by specialties (14 or more in mental hospitals) and by agencies (i.e., in-patient unit, the clinic, the rehabilitation center) is already too much for most clients or families to contend with. Poor people, sick people, and disadvantaged people do not have the cultural, psychological, or educational resources to thread their way without guidance through the tangle of agencies, procedures, regulations, restrictions, and expectations in the complex mental health services delivery system. They do not need more finely subspecialized technicians who work within a narrow range of highly developed skills--they need a single individual they can trust and who can help them to contact and work with the many specialist and agencies now available.
>
> Thus (the participants made) the recommendation that the highest priority of rationales for clustering of tasks and activities into jobs be "target groups of persons."

These target groups may be individual clients, families, small groups of clients, or a single neighborhood or community. This is the notion of the generalist. His primary focus is on meeting all of the needs of the target persons.

Therefore, a generalist has the following characteristics:

1. The generalist works with a limited number of clients or families (in consultation with other professionals) to provide "across the board" services as needed by the clients and their families.

2. The generalist is able to work in a variety of agencies and organizations that provide mental health services.

3. The generalist is able to work cooperatively with all of the existing professions in the field rather than affiliating directly with any one of the existing professions.

4. The generalist is familiar with a number of therapeutic services and techniques rather than specializing in one or two areas.

5. The generalist is a "beginning professional" who is expected to continue to learn and grow.

The history and these concepts form the basis of the major work of the Community College Mental Health Workers Project in developing curriculum guidelines for mental health worker programs in the two-year community colleges.

SECTION II

DEVELOPING CURRICULAR OBJECTIVES

Education is the process of changing the behavior of individuals. If behavior is defined as including knowledge, skills and attitudes, then education must include formal and informal aspects of the learning experience.

Formal education is a conscious process involving intent and planning; that is, it consciously plans and establishes a learning environment that is directed toward the purpose of making desired changes in behavior of students. When program directors speak of community college mental health worker curricula, they are talking about a formal aspect of education. But formal education is only one portion of the total learning experience. The colleges must consider the total environment of the learner when considering curriculum development.

In this report, curriculum is defined primarily as the formally structured activities that are carried out to achieve desired curricular objectives for development of selected knowledge, skills and attitudes in graduates of mental health programs.

Despite this rather limited definition of curriculum, other aspects of the learning experience must be considered. Students begin their higher education with several years of formal and informal education behind them. Their families, peer groups, the mass media, community organizations, government, etc., all have contributed directly and indirectly to their education. They come to college with a variety of backgrounds and experiences.

Program directors have identified four distinct groups of students entering community college mental health worker programs.

1. Recent high school graduates with no particular work experience.

2. Middle-aged housewives with little work experience whose children have reached school age.

3. Psychiatric aides and other employees of mental institutions who are attempting to upgrade their skills, usually in conjunction with their present work activities.

4. Individuals from the lower socio-economic groups and minority groups who are trying to move up the economic ladder--the New Careerists.

To provide learning experiences that are effective for all students, a curriculum should be flexible enough to allow a variety of experiences, depending on the students' backgrounds, and flexible enough to allow changes as new objectives emerge. Curriculum development, in this sense, becomes an ongoing process.

The Advisory Committee

The first step in planning a community college mental health worker program is identifying the need for the program. Do local mental health and human service agencies and programs feel the need for such workers? How many will they probably employ? These kinds of questions must first be answered.

Because the development of a program and the ultimate concentration on particular aspects of it are matters of judgement, the individuals and agencies that will be most affected by the graduates should be included early in the planning. This can be achieved by forming an Advisory Committee whose

major role will be to advise on local needs and curriculum content. If the generalist approach is taken, the members of the committee should represent a variety of professions and mental health agencies. A concentrated effort should be made to get agency personnel to accept the generalist concept, because the probability of developing a well accepted educational program is directly related to the degree of commitment and support of the service agencies.

Steps that could be taken when developing a community college mental health worker program are listed below:

1. Determine the need for middle-level mental health workers and decide which philosophical approach the college will take in meeting the need as indentified. This is the purpose and philosophical base for the program.

2. Decide the scope of the program--what the curriculum will encompass.

3. Assess the resources available to the program (i.e., funds, facilities, possible field experiences, characteristics of potential students, etc.).

4. Determine the curricular objectives. (What do we want the graduates to be?)

5. Operationalize the curricular objectives. (Exactly what knowledge, skills and values shall be expected of graduates and at what level of competence?)

6. Identify the learning experiences that will be used to achieve the curricular objectives.

7. Develop evaluative techniques to determine how well the curricular objectives have been achieved.

8. Develop evaluative techniques to determine whether the program is alleviating the need for which it was designed.

These steps will very likely lead to a redefinition of the purpose of the program and the curricular objectives, and the cycle will continue.

Purposes of Mental Health Worker Programs

The basic purpose of any community college mental health technology program is to meet society's needs for middle-level manpower in treating and restoring the mentally disabled, in preventing disability, and in promoting a high level of mental health in the population.

The mental health program directors at the regional curriculum development conferences stated that their major program purposes are:

> to develop mental health workers who are basically generalists and who can be employed in a variety of settings in the mental health field
>
> to develop workers who can also function as assistants to specialists under general supervision of the specialists
>
> to provide students with opportunities for educational mobility and transferability, both vertically and horizontally, and to support the Career Ladder concept in the mental health field.

The Philosophy of Mental Health Worker Programs

The philosophy of any program depends on the credoes, the values, the character of the organization, and the theories upon which the program is based (i.e., a psychoanalytic model, a social competence model, a behavioral learning model, etc.). Philosophies represent the differences between the denominations in the mental health "church." The philosophies of mental health programs have too often been left undefined, and yet they are the areas that most often raise conflicts.

The major differences between community college programs are based on different philosophical concepts concerning the nature of mental disorder and its management. Statements such as, "We take a Rogerian approach," or "We do not accept the medical model," "Our program is based on the behavior

modification model," and "We rely strongly on the Truax Triad for attitude development," were common during meetings with program directors. The same philosophical differences exist in the established mental health professions.

One way to keep the philosophical presuppositions which underlie any particular program from undue bias is to know consciously what they are. Obviously, every program is based to some extent on certain philosophical concepts; however, no field of endeavor that touches upon human lives to the extent that mental health programs do can long afford to leave its philosophical concepts unexamined. Such an examination does not necessarily mean that every belief will or should be established by reason, nor does it mean that various programs do not have the right to maintain certain emphases or biases. But such an analysis established the grounds upon which beliefs are held and the limitations of the reasoning used in determining program content.

In general, it will be most educationally valid to present the student with several alternative philosophies together with their implications (advantages, limitations, etc.) so that he may make his own choices of which approaches best suit his needs, even if the program has its own areas of emphasis. To do this most objectively, each program director needs a clearly defined statement of his program's philosophies and objectives.

Basic questions of philosophy were not discussed at the curriculum development meetings--not because they were considered unimportant, but because there was not enough time to consider such complex issues. However, participants agreed that in a pluralistic democratic society, differences in emphasis of philosophy will and should exist, but that every college attempting to develop a mental health worker curriculum should seriously analyze the philosophical presuppositions underlying its program.

Curriculum Objectives

Curricular objectives are defined in this booklet to be statements--in somewhat idealized terms--of what the graduates of the programs are to be. In this sense objectives are probably never really reachable since they express an ideal toward which the program strives.

Because it is impossible to provide a two-year curriculum that would encompass the total dimensions of human competence needed to work in *all* aspects of the mental health field, the selection of objectives in the two-year programs must be made according to the value judgements of those responsible for planning the curriculum. Nonetheless, the program directors generally agreed that there are certain overall curricular objectives that are common to all programs. At the same time there will be concentration on mastering certain areas of knowledge and skills unique to individual schools, depending on local needs. For example, most directors felt that the skill of administering psychological tests should not be commonly taught, although certain schools might include this because of local demand.

After deciding on curricular objectives, the next step is to decide how to "operationalize" the objectives. Operational objectives are statements, preferably measureable, of exactly what content knowledge, level of skill performance and attitudes will be expected of graduates. As an example, a curricular objective might be "to be able to do psychological tests of intelligence." This curricular objective might then be operationalized as "to be able to administer and score the short-form Wechsler Adult Intelligence Scale for individual clients and groups."

With precisely stated objectives, it should be possible to design a curriculum that will have sound rationales for any particular course content or activity that will build toward these objectives. Objectives that are vague are likely to result in outcomes that do not meet the intended purposes of the program. Each program should be able to state with some level of confidence and precision just what it intends for its graduates to possess in knowledge, skills and attitudes.

The program director should be careful to define objectives in terms of expected behaviors of the graduates rather than in terms of courses or credit hours. To do this, the specific behaviors desired of graduates must be identified and quantified, if possible. Once the objectives are clear, it is relatively easy to decide the course content, field experiences, etc., (in short, the curriculum) which will enable students to attain the objectives by the time they graduate.

There are certain questions that should be asked about objectives:

1. Are the curricular objectives consistent with the overall program objectives? For example, it would be inconsistent to set psychological testing skills as a curricular objective of a program that was training workers for agencies that did no psychological testing.

2. Are the objectives pertinent? For example, are advanced mathematical skills pertinent to human service skills?

3. Are the objectives at the same level of generalization?

4. Are the objectives stated in specific enough terms to be useful to everyone concerned--students, classroom faculty, field instructors, etc.?

5. Are the objectives attainable?

6. Are the objectives measurable?

If the curricular objectives and the operational objectives have been defined in specific and measurable behaviors, it should be possible to evaluate whether or not the objectives are being met, or to decide in what respects the curriculum needs to be modified in order to meet them. There are many methods of evaluation--written tests, skill performance tests, observations of behavior, self-evaluation, etc. The program directors have given some attention to the area of evaluation, but evaluation will not be further discussed in this booklet.

SECTION III

CORE OF COMPETENCE OF A MENTAL HEALTH WORKER AT THE ASSOCIATE OF ARTS LEVEL

This section attempts to define the core of competence the associate degree level mental health worker should have. "Core of competence" is defined as the competencies in the areas of knowledge, skills and attitudes that might be expected of an associate degree mental health worker at the start of his first job.

The term "core of competence" does not imply that all graduates of mental health worker programs must be alike or that all college training programs must be alike, but that there should be a consistent core of competence for all workers. Beyond this there can be all kinds of different emphases. An analogy may be drawn from a recent advertisement for an antiacid that appeared in several medical journals. The ad showed photographs of a dozen interns and had the heading, "Just as all interns are not alike, so all antiacids are not alike." While the ad used the theme of difference, it also made it clear that there are several ways in which antiacids are alike, that certain qualities are *virtually essential:* all antiacids must neutralize gastric acids and must be nontoxic in doing so. Other characteristics are *highly desirable:* antiacids should be palatable, should give sustained action without a compensatory hyperacidity, and should not cause constipation. Still other characteristics are *purely optional* and depend on personal circumstances and choices: the choice of liquid or tablet form, the choice of color and flavor, choice of a glass or plastic container.

The majority of college programs in mental health in the South are presently including most of the items considered to be virtually essential or highly desirable in their curricular objectives, but there is considerable variation in the specific operational objectives chosen by different programs, and there is substantial variation in the emphasis or concentration of each program. Thus some programs stress group counseling skills while others stress behavior modification skills, but all programs include some basic competence in all areas. The particular content and skill areas that make up the operational objectives and the areas of emphasis derive from the philosophical base of each program planner and local needs. This is as it should be.

It is not assumed that this definition of the competence of a mental health worker is final. It will undoubtedly be modified with future experience; however, it represents the best consensus of experts who have critically explored each item. These explorations were made not in the spirit of "what we can teach in two years" but rather in terms of "what should be the competence of the worker." While this section may be used to define the outcome objectives for students of mental health programs, it is not a curriculum statement as such. However, it was felt that a definition of the core of competence of such a student is rapidly becoming essential to the field, both for the community colleges to use as the objectives of their curricula and for mental health agencies to use as a basis for writing job descriptions and merit system examinations. Without such a consistent core, the graduates are not likely to be widely accepted or used.

The core of competence guideline presented in the following pages was discussed and agreed upon by small working committees made up largely of

college program directors; however, the inputs for the items came from three major sources:

1. A composite of the objectives of individual college programs as presented and discussed by all of the South's program directors at a meeting in January, 1970.

2. Descriptions of the work actually performed by 30 graduate mental health workers from all over the United States who had been employed in mental health agencies at least six months (from a study conducted in April and May, 1970).

3. The specific competencies implied for mental health workers in *Roles and Functions for Mental Health Workers*, a document that describes a rational framework for all levels of mental health workers. (This document uses the developmental approach.)

As the groups studied the elements of competence of a worker in a human service field such as mental health, it seemed that the competencies fell into three major areas: knowledge, skills, and attitudes. Obviously these are not areas that are exclusive of one another but rather they are centers of gravity that represent the major foci of competence. Every skill has a certain knowledge base--something the worker must *know about* the skill in order to perform it. But there is a difference in *knowing* about a skill and actually *performing* a skill. Too often college training programs have concentrated on learning *about* various skills rather than on the more important performance of the skills themselves.

While the group frequently spoke of the generalist and his core of competence in behavioral terms, they were also aware that the mental problems of people and the functions of the workers are more than just behavioral. Just as many persons who come to mental health centers have no abnormal or disturbing behavior but a feeling of lack of purpose and fulfillment that is

just as uncomfortable as if there were behavioral manifestations, so a mental health worker must be competent in areas other than just behavioral. He must be able to integrate these behavioral competencies into a purposeful and humanly sensitive concern than results in a truly helping relationship. It is for this reason that the section on values and attitudes has been added, for the worker's values and attitudes largely determine his tone and clinical manner.

The area of values and attitudes is often overlooked in professional education. It has been assumed that the scientific disciplines are "value free." On the other hand, some of the helping professions have rather uncritically assumed a set of values that may no longer be relevant in the face of modern technology and changing social developments. These values and attitudes need conscious definition and should be critically examined and integrated into the objectives for graduates and into the curriculum itself. Certain values should be internalized in the graduate himself, and there are other value systems that he should know about, regardless of what particular position he assumes as his personal belief. In any case, he should be aware of others' value systems as well as his own and the implication of each for his work with clients and communities.

The core of competence guideline does not consider characteristics which may be desirable for the worker; it was not decided whether personal characteristics are part of the core of competence, especially since there are many areas of work in the field of mental health that require different characteristics (for example, consultation, community education, etc., as client-centered work). While the matter of personal characteristics of mental health workers needs further study, it is not part of this section.

In attempting to set down the core of competence for mental health workers, the group used a simple four-point scale for classifying *levels of proficiencies* to be achieved. These levels of proficiency are highly tentative, and are not meant to be a strict, inflexible curriculum plan. They are meant to represent a guideline which might help program planners in their thinking about curricular objectives.

This core of competence listing is premised on the notion that colleges are preparing mental health generalists at the associate degree level. This does not imply that all mental health graduates will function as generalists, but that they should all have the competence to perform adequately as generalists if called upon to do so. This includes community mental health competence as well as clinical competence with individual clients, families, or groups of clients.

Levels of proficiency were identified for each of the three major areas--knowledge, skills and attitudes. The group also tried to identify the competencies of knowledge, skills and attitudes that were felt to be *virtually essential* for all workers, those that were felt to be *highly desirable*, and those that were felt to be *purely optional*.

The four-point scale for classifying levels of proficiency is:

Some knowledge--This implies familiarity with the elementary principles, terminology and skills of the subject sufficient to enable the worker to carry out the simplest work activities of the field.

Basic knowledge--This implies sufficient knowledge of the principles, terminology and skills of the subject to enable the worker to work effectively in normal situations of the field.

Considerable knowledge--This implies an advanced knowledge of the principles, terminology and skills of the subject sufficient to enable the worker to solve unusual and difficult problems in addition to the commonplace.

Extensive knowledge--This implies a level of principles, specialized knowledge and skills sufficient to have almost complete mastery of the subject, the ability to solve the most difficult problems, and ability to plan and advise on major policies.

For each item of competence there is noted the roles from *Roles and Functions for Mental Health Workers* for which the competence is felt to be needed. The associate degree mental health worker would correspond to the Level II worker as defined in *Roles and Functions for Mental Health Workers*.

KNOWLEDGE

Virtually Essential Knowledge

Knowledge of *Personality Theory and Function.* This might include:

Some knowledge of the most common concepts of normal personality growth and development from infancy to maturity and old age. Include orality and anality and their implications for personality functions.

Some knowledge of the terminology and basic concepts of the more common theories of psychological functioning (examples might be Freud, Adler, Adolf Meyer) and especially knowledge of the kinds of situations for which the various theories seem especially useful (i.e., psychoanalytic concepts for the neuroses, Adlerian concepts for general counseling, etc.).

Considerable knowledge of mental functions and their implications and applications.

Considerable knowledge of common personality patterns and behaviors (i.e., passivity, aggressiveness, dependence, independence, authoritarianism, compulsiveness, mood swings, etc.). All of this should be aimed at recognition and understanding the meaning for counseling and managing persons with these patterns.

Roles: Behavior changer (especially counseling and psychotherapy), Consultant, Community Planner, Evaluator, Teacher

Knowledge of *Abnormal Psychology:*

Considerable knowledge of abnormal behaviors; descriptions, natural history and psychodynamic aspects of psychoses, neurosis, personality disorders and psychophysiologic disorders.

Basic knowledge of psychopathologic conditions related to children, adolescents, and the aged as well as young and middle-life adults.

Basic knowledge of the behaviors, natural history and psychodynamics of special problems such as mental retardation, sex problems and alcohol and drug addiction and abuse.

Roles: Outreach worker, Evaluator, Behavior changer, Caregiver, Teacher, Consultant

Knowledge of the conceptual basis for various *Theories of Intervention:*

Basic knowledge of the various models for individual client intervention (i.e., medical model, social learning model, etc.).

Basic knowledge of the principles of treatment, palliation, supportive care, rehabilitation, partial disability, etc.

Basic knowledge of the concepts of prevention, positive health promotion, social system intervention, anticipatory guidance, etc.

Roles: Behavior changer, Evaluator, Community Planner, Mobilizer

Knowledge of the *Methods of Intervention with Individuals:*

Some knowledge of physical methods (what is done, rational, indication, what to expect, by whom):

electroconvulsive treatment
chemotherapies (not to prescribe, but to participate)
hydrotherapy (i.e., warm baths for relaxation)
physical therapy (i.e., exercise to drain off anxiety or anger)

Some knowledge of psychological methods (what is done, rational indications, limitations, what to expect):

non-directive methods (client centered)
psychotherapy (know *about* psychoanalysis)
counseling
short term eclectic methods (crisis intervention, hypnotherapy, supportive theory)
group methods (including family therapy)

Some knowledge of educational methods:

behavior therapy
rehabilitation

Considerable knowledge of social models:

therapeutic use of self
milieu therapy
activity therapies
therapeutic community

Some knowledge of community intervention:

consultation
community planning
public education
legislative and administrative process (especially at local community levels)

Roles: Evaluator, Behavior changer, Teacher, Consultant, Community Planner, Assistant to Specialist, Caregiver, Broker

Knowledge of uses, effects and abuses of *Chemotherapeutic Agents:*

Basic knowledge of major chemotherapeutic classes and agents:

anticonvulsants
tranquilizers
sedatives
narcotics
energizers
toxic, allergic, and side effects as well as therapeutic effects of most commonly used agents

Basic knowledge of what to do in the event of abuse or untoward effect.

Roles: Behavior changer, Outreach (aftercare), Caregiver, Consultant

Knowledge of the educational backgrounds, roles and functions and status considerations of the *Human Service Professionals:*

Basic knowledge about the mental health professionals and their profession's power and influence. (Medicine, psychiatry, psychology, social work and nursing)

Basic knowledge of mental health related professions. (Rehabilitation counseling, occupational therapy, chaplaincy, recreation, physical therapy, sociology)

Basic knowledge of middle-level mental health workers (psychiatric aides and attendants, mental health workers, etc.).

Roles: Advocate, Broker, Mobilizer, Community Planner, Assistant to Specialist

Knowledge of the *Mental Health and Mental Retardation Movements:*

Basic knowledge of definitions, terminology and history including value systems.

Basic knowledge of organizational, legal and fiscal structures of agencies and institutions and their functions at national, state and local levels.

Basic knowledge of major contemporary legislation and commitments.

Roles: Community Planner, Mobilizer, Advocate, Consultant, Broker, Administrator

Highly Desirable Knowledge

Knowledge of the *Social Welfare Field:*

Basic knowledge of scope of the field and theories underlying various programs.

Basic knowledge of specific agencies, their legal and fiscal bases and scope of operations:

vocational rehabilitation
corrections, parole and probation
public welfare
community action programs
voluntary agencies (i.e., Red Cross, Family Service, Boys and Girls Clubs)

Basic knowledge of the roles and functions of informal community resources:

school counselors, marriage counselors
private practitioners of medicine and psychiatry
clergymen

Roles: Broker, Advocate, Mobilizer, Community Planner, Consultant, Administrator

Knowledge of *Community Resources that Provide Human Services:*

Considerable knowledge of the resources available for the mentally disabled in each program, and how to

mobilize them on behalf of clients and the mentally disabled in general:

public agencies--local and statewide
voluntary agencies
private resources (hospitals, practitioners, etc.)

Roles: Broker, Consultant, Mobilizer, Advocate, Community Planner

Knowledge of *Sociology:*

Basic knowledge of concepts of role, social class, anomie, disengagement, etc.

Basic knowledge of concepts of family and kinship systems.

Basic knowledge of concepts of special group behaviors and their implications for practice:

institutions and agencies
professions
communities
minority groups
public officials

Basic knowledge of dynamics and processes of small and large groups and their uses.

Roles: Outreach, Broker, Mobilizer, Community Planner, Advocate, Consultant, Behavior changer, Teacher, Administrator

Knowledge of *Data Gathering Techniques and Evaluation Procedures in Mental Health:*

Basic knowledge of what is done, by whom, indications, rational implications at a basic level:

social history and vocational evaluation
physical and neurological examinations
mental status examinations and psychological tests
special studies--EEG, laboratory
questionnaires, community surveys

Roles: Evaluator, Community Planner, Data Manager, Consultant, Administrator

Knowledge of *Other Cultures and Value Systems:*

Some understanding of contrasting attitudes and viewpoints of other individuals and groups and of the need to accept them in interactions:

other national groups, minorities, social classes, etc.
other generations, rural-urban differences

Roles: Outreach worker, Broker, Mobilizer, Community Planner, Advocate

Knowledge of *Contemporary Events, Issues and Problems Relevant to Mental Health:*

Basic knowledge of state and local and federal laws and actions specific to mental health.

Basic knowledge of laws, issues and actions related to mental health (i.e., abortions for mental health reasons, insanity as a plea for criminal acts).

Basic knowledge of educational and professional issues relevant to mental health.

Roles: Community Planner, Advocate, Mobilizer, Consultant

Knowledge of the *Implications of Mental Illness and Retardation* for various target populations:

Basic knowledge of social, fiscal, legal and psychological issues:

families, children, adults
the disengaged (the aged, the divorced, widowed and single)
the poor, the rich, rural, urban
minority groups

Roles: Outreach worker, Broker, Mobilizer, Consultant, Advocate, Community Planner

Knowledge of *Physiology of Human Development and Function:*

Basic knowledge of human genetics.

Basic knowledge of normal physiology, endocrinology and neurophysiology.

Basic knowledge of normal sexual development and behavior.

Basic knowledge of pathological physiology in above areas.

Roles: Evaluator, Behavior changer, Consultant

Knowledge of *Self:*

Considerable self-knowledge of:

abilities, personality, values, philosophies, competencies, experiences, interpersonal style, disabilities, limitations, hang-ups, reaction patterns
motivations for this kind of work

Roles: Behavior changer, Teacher, Outreach worker, Broker, Advocate, Consultant, Community Planner, Mobilizer, Caregiver, Evaluator

SKILLS

Virtually Essential

Skills in *Interviewing* normal and disabled persons:

Basic skill in talking with people comfortably and productively.

Basic skill in obtaining information, "reading" the feeling tones of what people say, and observing and reporting the behaviors people exhibit in interviews.

Basic skill in giving and interpreting information and appropriately responding to feeling tones and to the implications of what people say and do in interviews.

Basic skill in relating to a wide range of the disabled --the aged, the mentally ill and retarded, children, alcoholics, etc.

Basic skill in sensing the impact of self on the person being interviewed, and responding appropriately.

Roles: Outreacher worker, Broker, Evaluator, Behavior changer, Teacher, Caregiver, Mobilizer, Consultant, Community Planner, Administrator

Skills in *Observing and Recording:*

Basic skill in observing behaviors, emotions and physical characteristics of people and settings.

Basic skill in using ordinary check forms to record observations.

Basic skill in recording observation and interview data in simple descriptive fashion (this does not mean interpretive language, i.e., "patient is delusional" but in graphic descriptions of exactly what the person is saying and doing).

Basic skill in recording subjective impressions of the individual.

Roles: Outreach worker, Evaluator, Teacher, Behavior changer, Consultant, Caregiver

Competence in *Interpersonal Skills:*

Basic skill in establishing interpersonal relationships with clients such as demonstrating the three characteristics described by Truax and Carkuff:

genuineness--the ability to be real
accurate empathy--the ability to correctly "hear" the other person
nonpossessive warmth--the ability to establish a caring but not a consuming relationship with the other person

Basic skill in dealing with other mental health workers in various role relationships.

Basic skill in supervising other workers (aides) in a consulting relationship.

Roles: Outreach worker, Broker, Advocate, Teacher, Behavior changer, Consultant, Mobilizer, Community Planner, Caregiver, Administrator

Competence in *Group Skills:*

Basic skill in organizing and developing groups as a group process facilitator or consultant rather than as a task leader.

Basic skill in leading groups as a task leader.

Basic skill in group counseling (i.e., giving information, exploring alternatives, effecting minor behavior change).

Basic skill in group teaching.

Some skill in group therapy including family therapy.

Roles: Mobilizer, Behavior changer, Teacher, Community Planner, Consultant, Caregiver, Advocate, Administrator

Skills in *Changing the Behavior and Enhancing the Emotional Growth* of individuals:

Basic skill in coaching for new behavior patterns (giving directions, persuading and practicing).

Basic skills in counseling for new behavior and adjustment in client patterns (helping explore alternatives, asking questions to lead the person to new insights, etc.).

Basic skill in behavior modification.

Some skill in psychotherapy.

(The worker should have *considerable* skill in at least one of these modes of behavior change, in addition to at least *some* skill in all modes.)

Roles: Behavior changer, Teacher, Consultant

Competence in *Instructional Skills:*

Basic skills in teaching ordinary skills and knowledge to individuals (i.e., grooming, knitting, etc.).

Basic skill in teaching small groups (i.e., a high school class about drug abuse. This will include use of visual aides, group discussions and other simple educational skills based on sound learning principles).

Roles: Teacher, Community Planner, Administrator

Skills in *Consultation:*

Basic skill in consulting with other workers about individuals and their problems (i.e., clarifying the problem, helping the consultee arrive at solutions and to carry the responsibility).

Basic skill in consulting with small local agencies about their mental health problems.

Roles: Consultant, Broker, Community Planner

Competence in *Community Process Skills:*

Some competence in neighborhood planning (i.e., serving as a member of a committee or board).

Basic competence in activating local community resources on behalf of a client or a program.

Roles: Community Planner, Mobilizer, Broker

Skill in *Mobilizing Community Resources* quickly:

Basic skill in working with community agencies, professionals, etc., to mobilize their services and competence quickly on behalf of clients. This may involve techniques for shortcutting standard "procedures" in the case of clients in crisis.

Basic skill in mobilizing community resources to serve classes of clients (i.e., convincing the local recreation program to include the mentally retarded).

This is the skill of "working the community" on behalf of the disabled.

Roles: Broker, Advocate, Mobilizer, Community Planner

Skill in *Problem Solving:*

Basic skill in evaluating the problems of a family or client, setting an action plan, implementing action and evaluating the result in order to modify the action for greater impact.

Basic skill in evaluating the problems of a group, agency or community, noting possible alternatives and consequences, setting a plan, implementing action and evaluating the result in order to modify the action.

Roles: Evaluator, Consultant, Outreach worker, Community Planner

Skill in *Gathering and using Mental Health Data:*

Basic skill in gathering clinical case data and in analyzing, abstracting and using such data in decision making with due regard for confidentiality.

Basic skill in gathering statistical data (i.e., numbers of cases), organizing it into systematic records, or

tables, analyzing and abstracting it as needed and using it for program planning and evaluation.

Roles: Data manager, Evaluation, Administrator, Community Planner

Competence in *Reporting Skills:*

Basic skill in organizing information into logical and clear reports:

in writing
in oral presentations

This includes reports of clinical information about patients or information about programs, problems or proposals.

Basic skill in presenting reports appropriately for professionals, peers or lay persons.

Roles: Evaluator, Data manager, Mobilizer, Consultant, Community Planner, Administrator

Competence in *Daily Living Skills:*

Basic competence in ordianry social adaptive skills (grooming, appropriate manners, sense of time, sense of responsibility, etc.).

This does not imply that each worker must himself be constantly a paragon of social propriety but that he should have the competence to use these skills when necessary to teach or counsel clients or to provide a role model to assist them with emotional and behavioral adjustments.

Basic competence in some of the more common special living skills (i.e., personal budgeting, home management, diet management).

Roles: Teacher, Behavior changer, Caregiver

Skill in *First Aid and First Level Physical Diagnosis* as related to the mentally ill:

This does not call for first aid in the full range of orthopedic situations, etc., or physical diagnosis

comparable to that of a nurse. Rather it is that level of skill in first level diagnosis that would be expected of a rather sophisticated parent.

Basic skill in recognizing the therapeutic, toxic, allergic and side effects of the most commonly used psychotropic drugs.

Basic skill in recognizing and evaluating the signs and symptoms of common illnesses (i.e., childhood diseases, heart attacks, epilepsy, drug abuse, delirium tremens). This probably should include basic skill in taking temperatures, pulses and respiration (and blood pressures) and knowing the basic significance of each.

Basic skill in first aid for common medical problems (heart attacks, epileptic seizures, etc., but not necessarily trauma as in highway accidents).

Basic skill in making appropriate referral or counseling clients and families when physical signs or symptoms present themselves. (This involves avoiding inappropriate and unnecessary referrals as in the case of a sophisticated parent).

Role: Evaluator, Behavior changer, Broker, Caregiver

Competence in some *Activity Skills:*

Some skills in a variety of recreational activities (table games, sports, exercises, dancing, etc.).

Some skills in a variety of crafts activities (sewing, art, photography, etc.).

Some skills in music activities (singing, instrument playing, band or orchestra, etc.).

Some skills in dramatic arts (plays, psychodrama, pageantry shows, etc.).

The worker should have some competence in all of these areas with considerable skill in at least one.

Roles: Teacher, Behavior changer, Caregiver, Outreach worker

Skills in *Advocacy:*

Basic skill in obtaining exceptions to rules, policies, practices, etc., when needed for individual clients.

Basic skill in bringing about changes in rules, regulations, policies, practices, etc., to obtain services for groups of clients (i.e., the mentally retarded, ex-mental patients).

Roles: Advocate, Community Planner, Mobilizer

Highly Desirable Skills

Competence in *Administrative Skills:*

Some competence in requisitioning supplies, recordkeeping and management, simple inventory procedures (i.e., for stock supplies).

Some competence in basic budgeting and fiscal recordkeeping (i.e., what will it cost to put on a weekend workshop for parents of the retarded?).

Roles: Administrator

Competence in *Management Skills:*

Basic skills in directing and supervising other persons (aides, volunteers, etc.).

Basic skills in evaluating work performance.

Basic skills in communication in organizations (i.e., formal communications, written communications, informal communications).

Roles: Administrator

Purely Optional Skills

Skills in *Administering Psychological Tests:*

Basic skills in administering certain screening and group psychological tests.

Basic skills in scoring and interpreting certain psychological tests.

Roles: Evaluator, Assistant to specialist

Basic skills in *Statistics and Research and Evaluation Methods and Techniques*.

Roles: Data manager

Basic skills in *Remotivation* and teaching of remotivation for aides.

Roles: Behavior changer, Caregiver

Basic skills in *Special Therapies* such as attitude therapy, play therapy, bibliotherapy, etc.

Roles: Behavior changer, Caregiver

Basic skills in *Conducting Special Tests* (i.e., neurological, neurophysiological or physical tests such as flicker fusion tests, electroencephalography, etc.).

Roles: Evaluator, Assistant to specialist

ATTITUDES AND VALUES

Virtually Essential Attitudes and Values

Considerable awareness of *One's Own Limitations* and willingness to seek assistance.

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Considerable conviction that the *Mental Health of Clients, Families and Communities Can Be Improved:*

Considerable conviction that the mental health worker can help bring about improvements.

Considerable intention to work to bring about improvements.

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Basic conviction that the *Work of Serving Clients Is Done Through Groups, Organizations and Agencies:*

Basic willingness to work within organized systems in serving clients.

Roles: Mobilizer, Community Planner, Advocate, Consultant

Basic conviction that *Organizations, Agencies and Social Policies Should Be Open to Change to Better Meet Client and Community Needs:*

Basic willingness to work toward appropriate changes in organizations, agencies and social policies to better meet client and community needs.

Roles: Advocate, Community Planner, Mobilizer, Consultant

Considerable conviction that *Knowledge, Skills and Attitudes are in Continuous Change* and that a *Commitment to Continuing Self-development and Education Is Necessary:*

Basic commitment to:

keep abreast of current relevant literature, events, etc.
give time and money to participation in continuing education activities
keep "loose" regarding new research, values, skills, etc.

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Thorough respect for the *Dignity of the Individual and a Respect for the Individual's Person, Privacy, Decisions and Opinions:*

Thorough conviction that no person shall be treated in demeaning, patronizing, condescending or arbitrary ways.

Thorough avoidance of labeling people with stereotyped or derogatory terminology (i.e., "prevert," "schizoids").

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Considerable conviction of the *Importance of Exercising Personal Responsibility and Initiative* in carrying out work:

Considerable conviction of:

the importance of being dependable and reliable in work with clients and communities
the importance of exercising personal initiative in carrying out work with clients and communities

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Thorough conviction of *Maintaining a Continuing Affirmative Relationship to Clients and Communities Whenever and as Long as It is Needed:*

Thorough conviction of need to respond and make oneself available whenever and wherever needed by the client (not just during working hours or when it is otherwise convenient).

Thorough conviction of need to continue to serve the client in some appropriate way (not necessarily to meet the client's or community's immediate demand).

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Highly Desirable Attitudes and Values

Considerable *Respect and Tolerance for "Different" Individual and Cultural Life Styles.*

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Considerable concern regarding *Contemporary Events, Issues and Problems Relevant to Mental Health:*

Sense of responsibility to facilitate positive solutions to contemporary problems and issues in appropriate ways.

Roles: Advocate, Mobilizer, Community Planner, Consultant, Broker

Considerable conviction of *Collaborative Team Effort* that promotes working with other professionals in the fields of mental health, social welfare, education, etc.:

> *Basic* conviction that all the human service professionals are working toward the same basic objectives though each from a different base (respect for differences).
>
> *Basic* conviction of responsibility to promote working with other professionals (rather than waiting for an invitation).

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Basic awareness of *Various Value Positions* and own value system regarding the Protestant work ethic:

> *Basic* awareness of the various attitudes held regarding the Protestant work ethic.
>
> *Considerable* awareness of own value system about work and the implications for worker's expectations of clients.

Roles: Behavior changer, Teacher, Caregiver

Considerable awareness of various value systems and of own value system regarding *Race and Racism:*

> *Considerable* awareness of the various attitudes held regarding race and racism and own values and attitude regarding race and racism and their manifestations in working with clients and communities.

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Administrator, Assistant to specialist

Basic awareness of various value systems and own value and attitude regarding *Human Life and Death:*

Basic awareness of:

how these issues are manifested in issues of birth control, abortion, prolonging life by technological means, sterilizations and euthanasia
own attitudes and possible implications in work with clients

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Basic awareness of own and society's attitudes and values regarding *Poverty, Dependency and Income Maintenance.*

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

Basic awareness of own and society's attitudes and values regarding *Physical and Mental Disability* and the persons afflicted with them (the mentally ill, the mentally retarded, sexual deviates, alcoholics, drug addicts, etc.).

Roles: Outreach worker, Broker, Evaluator, Teacher, Behavior changer, Mobilizer, Consultant, Community Planner, Caregiver, Data manager, Administrator, Assistant to specialist

SECTION IV

ACHIEVING CURRICULAR OBJECTIVES

Once the curricular objectives are stated in a way that makes it possible to measure the degree of knowledge, skills, and attitudes of students, it is the responsibility of the program director to develop learning experiences for students that will provide for the acquisition of the required abilities or characteristics.

Tyler[3] has presented five general principles that apply to the selection of learning experiences. (*"Learning experience"* is defined as the interaction of students with their environment. This infers that the student is an active participant in selecting the environment to which he will react.)

1. For a given objective to be attained, a student must have experiences that give him an opportunity to deal with the content and to practice the kind of behavior implied by the objective.

2. The learning experiences must be such that the student obtains satisfaction from carrying on the kind of behavior implied by the objectives.

3. The reactions desired in the learning experience must be within the range of possibility for the students involved.

4. There are many different learning experiences that can be used to attain the same educational objectives.

5. The same learning experience will usually bring about several outcomes.

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[3]Ralph W. Tyler, *Basic Principles of Curriculum and Instruction*, (Chicago: The University of Chicago Press, 1949), p. 3-62.

Listed below are statements concerning mental health curricula. These statements have been paraphrased from statements of general curriculum development compiled by Dressel[4] in *The Undergraduate Curriculum in Higher Education*. Program directors were asked to respond to a questionnaire based on Dressel's principles by either agreeing or disagreeing with Dressel. Below are the statements with which at least 70 percent of the program directors agreed. (Program directors unanimously agreed with 14 of 19 statements.) Some of the statements listed below are inconsistent with Dressel's original principles--for instance, Dressel stated that field experience[5] should be minimized, but program directors felt that field experience was a vital factor in the learning experience of mental health workers. The

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[4]Paul L. Dressel, "Principles for the Development of the Undergraduate Curriculum," *The Undergraduate Curriculum in Higher Education*, (New York: The Center for Applied Research in Education, 1963), Chapter V.

[5]Following are the operating definitions for field experience, practicum and work/study as the words are used in this paper.

> *Field Experience* means the kind of learning situation in which the student is placed in an agency setting or settings in a kind of "externship" to reinforce didactic learning with actual experience and to develop and sharpen skills. In essence, the agency accepts supervisory responsibility for the student during the experience, even though a seminar in conjunction with this is usually held by the faculty members.
>
> *Practicum* refers to the kind of learning situation which is a part of a regular course and occurs as a field trip to observe or participate in a particular experience relative to a classroom topic. The instructor maintains full supervisory responsibility for the student.
>
> *Work/Study* refers to the kind of learning situation where the student receives pay for work in an agency but combines this work with a college project to receive college credit.

following statements are based on responses to the questionnaire and discussions during the curriculum development meetings and seem to represent a concensus of opinions of the community college mental health program directors in the South:

> The total college experience of mental health students should be coherent, cumulative, and somehow unified by the development of broad competencies that are relevant to a future career as a mental health worker; the further development of the student as an individual; and the fulfillment of the student's obligations as a responsible citizen in a democratic society.
>
> The statement of objectives for a mental health program should include delineation of areas appropriate for study in terms of blocks of relevant knowledge, skills, and attitudes with a central purpose that will unify or integrate the curriculum.
>
> Some sequential characteristics should be present, insuring that depth in the field of mental health rather than superficial contact with a series of related disciplines is achieved.
>
> An identifiable core of organized knowledge, skills and attitudes in mental health should be included in a curriculum.
>
> Curricula should be planned to maintain as much flexibility in vocational choice by the student as is consistent with preparation for a career as a mental health worker.
>
> The objectives or levels of competency required for enrollment in and for completion of each course should be defined in sufficiently clear terms so that students may be properly placed or granted full credit for achievement, however attained.
>
> General education on the one hand, and breadth and depth in mental health knowledge, skills and attitudes on the other, should be pursued throughout the entire program.
>
> General education course offerings should be developed in relation to the needs of the total college or university rather than on narrow, specialized departmental concerns.
>
> One or more courses in the mental health department should be designated as independent study, to permit emphasis or specialization appropriate for individuals or small groups of students.

A mental health curriculum should include some attention to all relevant learning experiences (not solely to required course work), and acceleration by year-round attendance or by comprehensive examinations should be included in the curriculum.

Wherever possible, students should be encouraged and assisted to engage in work or service related to mental health in conjunction with their formal education.

Mental health students should be encouraged to use their electives to explore unknown or unfamiliar areas.

All students should enroll in an integrative interdepartmental student seminar.

A statement of the purpose and goals of the mental health program and a justification for all the requirements and their sequence should be available to advisors and to prospective majors.

The instructional method and requirements of individual courses should be known to students and advisors so that the program planned for the student may include field experience, writing, speaking, discussion, case method and other learning experiences significant in attaining a broad general education.

Early in the college career of each student, his entire college program should be tentatively mapped out by the student and the advisor.

A student should have an advisor who is in the mental health department.

A wide variety of field experience or practicum should be combined with classroom experience so that students will have an opportunity to apply skills as they learn them.

These statements refer to activities of both the college and the mental health program. They are achieved by community college mental health programs by fairly traditional administrative methods in the South. Generally the colleges provide for a number of college credits that can be attained in a quarter, trimester or semester. Table I indicates average curricula offerings in the mental health programs in the South and describes the

average number of hours and percentage of courses included in the mental health curricula according to a general education--mental health dichotomy.

TABLE I

Curricular Offering According to General Education/Mental Health Core Comparison in Community Colleges in the South

Type	Percent	Hours*
Required General Education (not related to mental health core)	25	15
Required General Education (part of mental health core)	25	15
Required Mental Health Courses (not considered as general education by college)	30	18
Electives related to mental health	10	6
Free electives	10	6
Totals	100	60

*Based on 60-hour curriculum

General Education refers to courses offered in the humanities, physical sciences, social sciences or behavioral sciences. In many colleges a number of courses within the mental health concentration are offered in either the social or behavioral sciences. Introductory courses such as health, psychology or sociology are usually offered on a college-wide basis and considered as part of the general education curriculum for college parallel majors. Because of this overlapping, the mental health curriculum may have a large percentage (25 percent) of courses within the mental health concentration that are also considered as general education courses. The mental

health curricula also have a large percentage (30 percent) of courses required for all mental health majors.

College mental health program directors have reported that in junior colleges it is often quite easy to sit down with the faculty persons who teach these general education courses and work out curricular offerings that are more useful to students entering the human services in general. For example, it is often possible to assure that general psychology courses feature more learning about human psychology than about animal or experimental psychology, emphasis which is much more likely to be useful to students who plan to become nurses, teachers, physicians, lawyers, salesmen or mental health workers. The same is true for other courses such as sociology or biology (human biology--not so much of plants and insects).

The Mental Health Core

In many of the programs, mental health is considered as part of a larger core of courses. To achieve better administrative efficiency and educational continuity, it is feasible to group students in different majors together to increase class size and to provide better understanding and communication among workers in related fields.

There are two distinct kinds of cores for mental health workers in the South. The first has grown out of the traditional health-related field in which the core is usually designed by grouping nursing, medical technology, dental technology, hospital management, radiological technology, physical therapy, etc., with mental health technology and some of the other therapies. This trend has developed because the health-related curricula in community colleges have common objectives and course offerings in the medical services

area. Such a core has students from all health-related programs taking courses that teach common knowledge, skills and attitudes needed during the first year and more specialized courses in their particular major during the latter part of the two-year schedule.

A second core that is emerging might be termed a "human services" or "social welfare" core. The human services core usually revolves around information that is common to the professional fields of social welfare--psychology; sociology; psychiatry; mental retardation; vocational or correctional rehabilitation; occupational, recreational, craft or music therapy; and educational counseling.

There are three objectives for mental health worker programs that are rather different from those of most community college curricula and that lead to different kinds of educational processes.

First, the students are expected to *learn more about themselves*--their values, attitudes, motivations; their styles, personalities, feelings and hang-ups. This has led to the use of group participation, T-groups, sensitivity training, role playing, group dynamics and other methods of experiencing and confronting oneself.

Second, students are expected to *master more skills that involve the use of self as a therapeutic tool*--counseling, coaching, teaching, behavior modification, group and individual therapy. This has led to the use of various experiential learning methods--seminars, group discussions of performance, practicum experiences under supervision, videotape playbacks of performance, simulations, etc.

Third, students are expected to *develop basic competence in helping real people and communities solve mental health problems*. The student is expected to be able to apply the sum total of his knowledge, skills and attitudes to helping disturbed and disabled clients and families to resolve their problems. This has led to *much* stronger emphasis on field experiences and practicum activities with real people with real problems in the field.

Some people have referred to these kinds of experiential learning techniques as process-oriented--as contrasted with didactic content-oriented--education. In the mental health curricula there is still a heavy emphasis on content which must exist even as a base for the experiential learning of human service skills and problem solving, but there is much greater emphasis, in addition, on process-oriented courses.

Table II notes that students in community college mental health worker programs in the South are spending approximately 30 percent of their college time in courses that are process-oriented. This does not reflect the number of college credit hours since students in mental health programs are required to spend more actual time in class than most other students. Mental health worker programs are definitely not "snap" or "cinch" programs.

The format for the process courses varies tremendously. A few schools have extended sessions of three to five days in which students and faculty meet together for all-day sessions to concentrate on learning about oneself, ones attitudes, values, hang-ups, motivations, etc. Some of the programs utilize sensitivity training techniques developed by the National Training Laboratories, but most use discussion groups or seminars to discuss what

they have learned about themselves through field experiences, films, lectures or textbooks during the content-oriented phase of the program. All of the programs combine a student seminar with field experience, and much of this seminar is directed to increasing the student's awareness of himself as well as the clients and services that he has worked with in the field.

TABLE II

Teaching Method Utilized (By Semester) in Community College Mental Health Programs in the South

Teaching Method	Percent of Student Time Semester 1st	2nd	3rd	4th	Percent Average Total (Time in Parentheses)	
Content-Oriented	40	30	20	10	25	(500 hours)
Process-Oriented	30	30	30	30	30	(600 hours)
Practicum	30	40	20	10	25	(500 hours)
Field Experience	X	X	30	50	20	(400 hours)
						(2000 hours)

One percent equals approximately 20 student contact hours

The reasons for which these process-oriented courses are offered differ from school to school. Some of the stated reasons are: to provide for personal evaluation of values and attitudes, to provide for learning by doing experiential learning (i.e., group process), to provide a means of self-screening for students before enrollment or early in the program, to provide students a mechanism for self-analysis and self-evaluation, to provide experiences similar to those that the graduate will be expected to provide for clients, to develop *esprit de corps* among students, to provide

a laboratory to practice learned skills (i.e., role playing and group leadership), to provide a means for students to react to course content or field experience, and to provide opportunity for feedback and program evaluation by the students.

Below is an excerpt from a process-oriented course offered at Purdue:

> This course is designed to focus in detail on certain critical issues in your continued growth as workers in the field of mental health. In addition, certain key areas of knowledge not covered in previous courses will be filled in. The general objective of the course is to round out your knowledge, allow for integration of diverse knowledge and experiences and bring about the final preparation for job entry. The staff is willing to consider additions or substitutions which you may want.
>
> A seminar is unlike other college classes. Each member has the opportunity and responsibility to share his own findings. Because the hours are primarily for sharing, it is important for each student to be present at each session.
>
> Usually, a term paper has been prepared for this course. However, this year a creative and original project may be substituted. Such projects will be accompanied by an explanation (one or two pages) and a bibliography of background information and the needs which exist in that field.
>
> Two or three students may join on a subject with each student being responsible for a section of the total. This project/paper will determine the final grade with attendance also being a determining factor.

Field Experience

The second way in which mental health programs differ from other community college programs is in the amount of practicum, field experience and work/study courses that are provided. On an average, students are required to take 6 to 12 hours (10 to 20 percent of credit hours) or practium and field experience; however, as noted in Table II, this represents 45 percent of the student's time.

The settings for practicum and field experiences should be many and varied. Currently they include mental health centers, facilities for the retarded, state mental hospitals, school counseling services, family service agencies, correctional institutions, training schools, alcoholic units, drug addiction units, neighborhood health centers, agencies specializing in the care of the aged and chronically ill, hospital psychiatric units, children's units, and child day care centers. Many of the early graduates have urged a greater variety of field experiences. One or two settings are not enough. Some of the settings should be community agencies--not just state hospitals or institutions for the retarded.

The problems most often stated by program directors concern field placements. Both the number and variety of field experience placements available to some programs are so limited that many programs in rural areas are having to limit their placements to only a few agencies or institutions. However, students can learn many essential skills and values from non-traditional settings such as nursing homes, sheltered workshops, and day care centers. There is no need to limit the settings to mental health agencies. Nor it it even desirable to do so.

As noted in Table II, most of the mental health programs are designed with some practicum experience being offered during the first and second semesters with field experience following in the summer and throughout the second year. Early practicum experience usually exposes students to community service agencies and potential clients and to the more basic skills such as interviewing, observing and reporting. Another type of practicum experience exposes the students to representatives from various professional disciplines and to more seriously disabled people and more sophisticated skills such as

counseling, behavior modification and administration. Many observers feel that this use of practicum experiences from the very beginning of the program and continuing throughout the program is one of the real strengths of the community college mental health worker programs.

Field experience involves actual therapeutic relationships with clients. The majority of field experience in current programs is in mental hospitals or mental health centers located in the city where the college program is being conducted. Some field experience is conducted during the summer between the freshman and sophomore years over a period of three to six weeks. The focus is on sophisticated skills of therapy, teaching and client problem solving. Most programs feel a need to give students a more comprehensive experience in community mental health and all that it implies.

Almost all of the existing mental health programs have a written contract between the college and the mental health agencies for the provision of field experiences. The contract spells out areas of shared responsibility and areas of separate responsibility through statements about:

the duration of the agreement

those responsible for instructional planning

any consultation commitments necessary

the use to be made of facilities, and responsibility for equipment

provisions for special needs of students when in the mental health facility; i.e., conference space, cafeteria, personal storage space

responsibilities for supervision and instruction

definition of "adequate supervision" to protect the student against implication of negligence

any provision either party will make to meet special student health requirements of the field placement organizations.

Some of the mental health programs offer summer work/study programs. Students work for pay during the summer, usually in a mental hospital, mental health center, or school for the mentally retarded. Some of these work situations are combined with classroom work, individual study, or a research course to form a work/study session for college credit. Some colleges also give college credit for work related to mental health performed either before or during the student's two-year formal education.

Some colleges are offering courses within mental health institutions to upgrade the skills of psychiatric aides and others. These courses are often offered during working hours and for college credit, in an effort to integrate on-the-job education and formal college education--a prime consideration in the development of career ladders. Some hospitals are allowing their aides and attendants to be paid full time while working part time and attending college part time.

Identifying the role of the student field placement supervisor is a problem that has been dealt with in a variety of ways. In a few instances the director of the mental health worker program or a faculty member at the college has supervised field placement students. The most common method is for the supervisor to be an employee of the institution or agency in which field placement is made and to supervise students on field placement as part of his responsibilities within his own organization. Sometimes the college pays part of the supervisor's salary. A few colleges have contracted with an agency for all members of the agency's staff to provide both field placement supervision and part-time faculty teaching assistance. Along with this, the staff is usually listed as part-time faculty of the college.

This latter plan seems to provide the best continuity between the agencies and the college and seems to make the agency personnel feel more responsible for the kind of graduate that comes out of the program. In most cases, it also provides an educational variety that may not otherwise be available to the student since many of the staff represent different professional backgrounds. There may be legal complications to be considered when the college or agency is receiving public funds, but these problems have been overcome in communities where this plan has been instituted.

The mental health program director must be careful not to send the students to an agency for practicum or field experience without making it quite clear to the supervisors in the agency just what he expects the students to learn in knowledge, skills and attitudes from the experience. The program director is ultimately responsible for the student's developing the desired competencies--a responsibility he must not evade by substituting "hours" or "days" the student spends in an agency for spelling out and defining for the supervisors what competencies are expected.

Various approaches have been used for helping the supervisors do their jobs better:

have them participate as faculty members in the curriculum planning

have formally structured orientation sessions for all field instructors so they are all clear on what objectives are to be met at which times and places

have regular monthly (or more frequent) meetings, perhaps at lunchtime over a sandwich, at which student progress is reviewed and any changes in the field experience for students planned. Such regular sessions give the field instructors a stronger commitment and involvement with the program's objectives.

Along with the agreement for the student to be assigned to the total agency rather than to any one professional (i.e., a psychiatric nurse, a psychologist, a social worker), a strong recommendation is for mental health students to be placed administratively under the director of the agency or hospital division in which they are working. The director is best able to assign priorities for activities in relation to the overall program goals and can see that the student receives a variety of experiences consistent with the roles in which a generalist is expected to function. This should diminish pressures of rivalries between professions that tend toward individual professional role biases, and it can help avoid administrative classifications such as "assistant social worker" which can thwart the evolution of a relatively independent mental health generalist. "Second class" or "assistant" field placements will very likely lead to "second class" or "assistant" status for mental health worker graduates.

Even though a few colleges do not require or provide summer employment in a mental health organization, all of the programs encourage such employment. It is felt that no field experience can duplicate the learning experience gained on a real job. It also gives the students an opportunity to reassess career choices prior to taking many of the more advanced specialized courses that will have less chance for transfer should the student later decide to change majors.

Problems in Program Development

Program directors who attended the various curriculum development meetings in 1970 listed a number of problems that they had encountered in developing curricula for new mental health worker programs. These problems do not

necessarily occur in every college, but they are problems that might be anticipated by anyone attempting to establish a mental health worker program.

Some of the problems can be grouped under a general administrative heading:

> The administrative mechanism of the college and state system is cumbersome (bureaucracy). Innovations are sometimes difficult to implement. This requires special skills of advocacy.
>
> It is difficult to establish adequate communicative devices to allow the college and agencies' top-level decision makers an opportunity to understand the program.
>
> It is difficult to justify financially new mental health worker programs because of the small numbers of students.

Another group of difficulties might be called program development problems for the mental health curricula:

> It is sometimes difficult to work within the overall philosophy of the college.
>
> It is difficult to combine the practical needs of potential employers and the academic requirements of the college.
>
> It is difficult to define the "outer limits" of mental health with regard to the scope and depth of the curriculum.
>
> In early stages, programs have had ill-defined goals and objectives.
>
> The mechanics of establishing a new curriculum are difficult; i.e., problems of sequence, integration, continuity, prerequisites. This is especially a problem with practicum and field experience courses.
>
> "Quality control" of the field experience and supervision of students on field placement is a problem.
>
> Developing mental health worker curricula that have a high percentage of transferability to upper division colleges is a problem.
>
> There is a problem in developing an educational program that will meet local agency needs and yet provide for student mobility and some basic standardization for college programs throughout the region.

A few problems might be termed faculty/student problems:

Methods of recruiting and screening better mental health students are needed.

There has been a gap between faculty expectations of students and student abilities.

The most practical problems listed during the conference dealt with the actual teaching situation:

There are too few trained faculty who understand and accept the generalist approach to educating mental health workers. They think in terms of aides to specialist.

There is a critical scarcity of educational devices (i.e., text-books, films) for teaching mental health workers.

The final problems revolve around placing graduates on jobs:

There is a question in many of the program director's minds of how and how soon the generalist graduates will be accepted on the job by the existing professions.

SECTION V

INNOVATIONS IN COMMUNITY COLLEGE MENTAL HEALTH WORKER PROGRAMS

If innovation is "the introduction of something new or something that differs from existing forms," then the existence of a mental health worker program in the community colleges is in itself an innovation. These programs are new to the South and to the nation; however, some of the colleges have planned innovative methods of organizing, conducting and presenting course content--innovative in the sense that they are new and different forms of the usual methods or techniques of teaching course content, providing field experience, providing work/study programs, and the like. Some of these innovations are described here for the benefit of program planners who may wish to use similar techniques in their programs.

Inclusion of a program here does not necessarily constitute endorsement by the project. Similarly, the omission of an innovative technique should not be construed as criticism. In many cases, the techniques discussed here are included because project staff have been made aware of them. There are probably many more innovations in programs that have not been brought to attention of the staff.

Introductory Techniques

The community college mental health program directors have found a number of new ways to introduce students to the mental health program and to screen students in and out of the program during the early stages of the curriculum. Western Piedmont Community College and Sandhills Community College (North Carolina) expose prospective students to a four-day sensitivity group

prior to the regular school session. The primary purpose of this exposure is to give students an opportunity to review their own feelings about entering a program where they will have to deal intimately with their own feelings about mental health and mental illness, and to learn more about themselves and their interactions with other people.

Many programs use interviews to select students. Daytona Beach Junior College (Florida) and Jefferson State Junior College (Birmingham, Alabama) interview prospective students to select some for scholorships. Most of the community colleges have an open door policy which allows any student to enroll in the mental health course; however, many of the program directors counsel the students regarding their possible success in the program.

At Santa Fe Junior College (Gainesville, Florida), the human services program is advertised extensively through local newspapers, and the college receives approximately 80 applicants per quarter for a program that can only accommodate 30 students. Students are screened in a 15 minute interview, after which time they are asked to counsel a student already in the program concerning a real problem. This initial counseling session is videotaped and reviewed by a team of counselors working with the program. Students are selected on the basis of their ability to relate openly to the counselee and to reflect and clarify feelings. Students who are not selected are again counseled by the program director about possible alternatives.

At Catonsville Community College (Baltimore, Maryland) an introductory course in mental health is designed to expose the students to institutionalized patients. In the course students are expected to work on a simple behavior modification project with a patient in a mental hospital.

At Sandhills Community College, students are placed in a rehabilitation and socialization ward of a mental hospital during their first semester. They spend a weekend in the ward with patients in order to become more sensitive to the living conditions and the patients in a mental hospital.

Many programs have introductory courses that are open to any student in the college. Most of these courses are designed to expose students to the field of mental health and to the agencies and institutions that provide mental health services. In most of these courses, students are also exposed to people with a variety of problems. The Community College of Baltimore (Maryland) has an introductory course called the Social Interaction Program. Students who register for the SIP program spend at least 10 sessions during a semester in direct contact with patients in one of the four mental hospitals in Maryland. Students are asked to interact with the patients and to participate in occupational and recreational therapy sessions. In some instances, students have been involved in staff sessions. The college reports that many students are so enthusiastic they continue their visits to the hospital after their required 10 sessions have been completed. In the fall of 1970, 73 students registered for daytime sessions and 55 for evening sessions.

Process-Oriented Education

As previously mentioned, all of the mental health programs are stressing experiential courses in which the student learns by his own participation in an experience. Montgomery Community College (Maryland) Western Piedmont, Sandhills, Jefferson State, Greenville Tech (South Carolina), and Daytona Beach Junior College are putting primary emphasis on experiential learning.

Western Piedmont and Sandhills have held weekend sensitivity sessions with students from both colleges. Western Piedmont will sponsor a seven-day sensitivity session in June of 1971, with students from all five North Carolina mental health programs invited to participate. These are in addition to the many techniques already listed such as group dynamics seminars, videotape playbacks, and experiences with patients.

Field Experience

Every community college provides field experience for their mental health students. Some of these placements are in traditional mental health settings or agencies, but a great many are in other kinds of human service agencies in the community. These are often the better placements.

The Community College of Baltimore surveyed all agencies in the city of Baltimore that might provide some form of field experience for their students. This was followed up with an interview if the agencies stated that they were interested in placing students for practicum and field experience. As a result the college has a vast resource for potential field placement.

Jefferson State Junior College provides a 12-week field placement in Tuscaloosa, Alabama. The students live in a nursing residence at Bryce Mental Hospital and take their field experience at Bryce, the Veterans Hospital, and a mental retardation residential center in Tuscaloosa. Jefferson State and Sandhills have also exchanged students during the summer for field placement.

Daytona Beach Junior College has taken a somewhat different approach to their field experience. Students take almost all of their field experience at

the Guidance Center, the day care branch of the comprehensive mental health center adjacent to the college campus. The college varies the types of problems with which the field placement students work and therefore feel that the location of the field experience is not necessarily limiting to the educational process. Gadsden State Junior College (Alabama) is training students to work in a comprehensive mental health center in Gadsden. However, the center has not been completed and students have been taking field experience in other locations in Gadsden and surrounding communities. The program director reports that one of the better field experiences has been at the TB hospital in Gadsden where students have been exposed to many psychological problems, including alcoholism, that are related to the basic physiological problem of the patients.

Georgia State University (Atlanta), Jefferson State and Community College of Baltimore are all offering field experiences in the college guidance and counseling office where students assist other students with problems associated with the college. At Essex Community College (Maryland) the student government established a counseling center on the college campus. It is a student-sponsored project, called the Room Three Project, and provides counseling services for any types of problems. Mental health students work with many of the social and psychological problems of students, and use faculty members in a consultative role.

At Pitt Technical Institute (North Carolina) and Georgia State University, students man "hotlines" for drug users and for potential suicide victims.

At Montgomery Community College female students have been placed in a male adolescent correctional institution. The program director reports there

was some initial reservations about the security of the students, but they have been quite successful in improving the behavior of the residents. Montgomery has also worked out an agreement with field placement agencies in which students are allowed to work "overtime" for pay after their field placement.

Core Programs

A method of providing an opportunity for students to delay a choice of major is through the utilization of a core program. Galveston Community College (Texas) has a core that encompasses nine health-related programs, including mental health. Students are not allowed to announce their major until the end of the first year. St. Petersburg Junior College (Florida) has a similar health-related core with a strong emphasis on mental retardation and mental health. Essex Community College has a core that combines social welfare and mental health courses. Central Piedmont Community College (North Carolina) has a human services core that encompasses six majors, including teaching and vocational rehabilitation as well as mental health and mental retardation.

Santa Fe Junior College offers another unique core requirement. The human services worker core consists of a group dynamics course dealing with individual and group communications and interaction; a three-hour mini-lab where students counsel each other and evaluate their counseling techniques in small groups through the use of videotape playbacks; and a discussion-lecture course about theories underlying human interaction.

Independent Study

Almost every college offers at least one course of independent study where students are allowed to work independently to accomplish prearranged behavioral objectives. This technique attacks the traditional assumption that students only learn under the guidance of an instructor. Under such arrangements students spend very little time with instructors and more time in independent study. This also allows the instructor to concentrate more on individualized instruction where necessary.

Work/Study Designs

The State Department of Mental Health in Maryland has developed a work/study program for selected employees in which the employees are paid for a 40-hour week while working 20 hours and attending a mental health course in one of the Maryland community colleges full time. As a result, these employees have been able to move up to more responsible positions in the department. Cherry Hospital (Goldsboro, North Carolina) has worked out a work/study program with Wayne Community College (Goldsboro) in which the college conducts mental health courses at the hospital during working hours for college credit in order to upgrade the staff of the hospital. As a result of this part-time program, Wayne is beginning an associate degree mental health program in the fall of 1971.

The Formation of Consortia

The seven community college programs in North and South Carolina (Western Piedmont, Sandhills, Lenore Community College, Pitt Technical Institute, Central Piedmont in North Carolina; Greenville Tech and Midland

Tech in South Carolina) held a number of meetings in 1970-71 in an attempt to develop a consortium of mental health programs in those states. The program directors listed the objectives as: 1) to assist the colleges' program development; 2) to provide a mechanism for exchange of faculty members; 3) to supplement existing faculty with expertise in specialized fields; 4) to provide a mechanism for exchange of students; 5) to assist the colleges in working with state departments to develop career ladders; and 6) to assist the colleges in research and evaluation.

At a statewide meeting of community college and mental health agency representatives in Birmingham, Alabama, it was recommended that community colleges and mental health agencies and institutions in Alabama form a consortium to provide for improved field experience and a faculty exchange program between the junior colleges and the agencies and institutions.

Evaluation

Many of the colleges have worked out innovative methods of evaluating students. Santa Fe Junior College has a policy that students will not be given failing grades, but will be given a X which the students can bring up to a passing grade by doing additional work. Santa Fe Junior College and Community College of Baltimore use a student group along with a counselor/instructor to evaluate videotapes of counseling sessions. Community College of Baltimore, Catonsville, and Jefferson State base their field experience evaluation on proficiency in the interpersonal skills, sometimes termed the Truax Triad, with students being systematically evaluated on their genuineness, warmth and empathy.

At Western Piedmont Community College, students learn in small groups of six to eight members. Each person is responsible for teaching some portion of the content of courses as well as evaluating other members of the group. Evaluation criteria are explained to the students, and the students and the instructor grade every student in the group on the basis of preparation, control, rapport, participation, self-expression, interest, effort, empathy, and objectivity. Students thus simultaneously learn teaching skills, group skills, and mental health or family life content.

Many of the colleges are adopting contract methods for evaluation. There are many types of contracts, but basically they consist of an agreement between the faculty member and the student, specifiying that if the student performs certain tasks and activities at a predetermined level of competence, he will receive a certain grade. The contract method has been devised to remove any personalized threat that the faculty member may represent to students, thus improving the learning potential between the faculty member and the student.

Other Innovative Techniques

Santa Fe Community College and Jefferson State Junior College require their students to submit a certain number of "reaction papers" which are required but not graded. The student is asked to react confidentially to the instructor about any subject that he feels is worthwhile to write about. The instructor then reacts to the paper, either in writing or verbally.

Santa Fe has also added a personalized dimension to their program by having the students in the program decorate the meeting room in any manner

they wish. The students painted the room, found carpet for the floor and put posters on the wall depicting the "self" of each student.

Western Piedmont has adapted a form that was originally used to select volunteers for agencies to survey what activities and interests students have when they enter the program. This comprehensive list has provided a means for identifying many talents of students, and in some instances the results have been used therapeutically with clients. For example, students have put on a number of talent shows for patients at Broughton Hospital in Morganton, North Carolina. This helps students to know how they project themselves to other people and how to improve this skill.

As noted in the beginning of this section, this is probably not a complete list of innovative techniques that are being used in the community college mental health programs of the South. However, the project staff hopes that the list may give planners ideas for innovations in their programs.

The project staff has collected course outlines and course syllabi describing the courses in all programs in the South established before April, 1971. It has also compiled a sample mental health program booklet that is available on loan from the project. Anyone interested in the total curricular offering of any particular program in the South may write to the project for a copy of the program, or may borrow the booklet which lists many aspects of all programs.

CONCLUDING REMARKS

The community college mental health graduate is a new level of worker, and the "generalist" idea is a new concept of the kind of work he will do. It is a new way of relating to clients and of delivering mental health services, and new educational experiences and curricula are needed to prepare this special person. One of the purposes of this publication is to help program planners consider all aspects of the preparation of the worker himself.

But equally important is the preparation of the agencies and service facilities to receive and use the mental health graduate when he hits the job market. There seems to be little point in preparing a mental health generalist for which there are no jobs or jobs that do not allow the worker to use the skills and knowledge gained during his two years of preparation. The program director's obligations do not end with the production of a well-educated mental health graduate--he has a further obligation to work with agencies where graduates will expect to be employed and to help agency personnel understand the purpose and implications of the generalist approach and to make the most appropriate use of graduates. Agency people will need to understand what graduates are prepared to do and provide jobs that are real career opportunities instead of deadend jobs that only allow the worker to serve as "assistant to the professional."

Program directors and other faculty people in the community college mental health worker programs may work with agency personnel through personal visits, workshops and conferences, professional society meetings, staff

meetings, and by placing their students in the agencies for field experience. Agency personnel should also be included as members of advisory committees for curriculum planning.

Regardless of the means by which the agencies are prepared to accept, understand and use the workers, the programs must be promoted and sold to the agencies, or they will fail, no matter how well developed the curriculum or how well prepared the graduate.

Agencies that need help in writing job descriptions, budgeting positions, and preparing the agency and community to accept the new workers should feel free to call on program directors and the college faculty for assistance. Better still, the program directors should offer this kind of help early in planning a mental health worker program, so that agencies can do a better job of extending mental health services to all people by taking full advantage of the skills and knowledge of the generalist worker.

APPENDIX

CURRICULUM DEVELOPMENT MEETINGS
LIST OF PARTICIPANTS

1. January 20-24, 1970 -- Atlanta, Georgia
2. April 30, May 1-2, 1970 -- Atlanta, Georgia
3. October 8-9, 1970 -- Baltimore, Maryland
4. October 29-30, 1970 -- Southern Pines, North Carolina
5. November 17-18, 1970 -- Greenville, South Carolina
6. November 19-20, 1970 -- Morganton, North Carolina
7. February 17-19, 1971 -- New Orleans, Louisiana

Numbers in parentheses represent meetings attended
* Represents program director

SREB Colleges Represented

Alabama

Gadsden State Junior College
Gadsden 35903
Mr. Newell Massey* (1,2,7)

Jefferson State Junior College
Birmingham 35215
Dr. Jeanette Redford* (1,2,3,4)
Miss Geneva Folsom (1,7)

N. E. Alabama State Junior College
Rainesville 35986
Mr. Wayne Wood (7)

Florida

Brevard Junior College
Cocoa 32922
Dr. W. W. Wagner (7)

Chipola Junior College
Marianna 32446
Mr. C. H. Gesslein* (7)
Dr. John McFarland (7)

Daytona Beach Junior College
Daytona Beach 32015
Miss Louise Atty* (4,7)
Mrs. Lillian Bartlett (1)

Miami-Dade Junior College
Miami 33167
Mr. Kenneth Orkin* (2,7)
Mrs. Marianne Brauzer (1)

Palm Beach Junior College
Lake Worth 33460
Mrs. Eleanor Salisbury* (7)

Santa Fe Junior College
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